MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

COMPANION GUIDE FOR THE HIPAA 837 PROFESSIONAL ENCOUNTER ADDENDA VERSION 4010A1

Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Service Programs (CMHSPs)

May 21, 2004

Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim Addenda, ASC X12N 837 (004010X098A1)**, dated October 2002, and the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim, ASC X12N 837 (004010X098)** dated May 2000. This document should be used in conjunction with all MDCH encounter submission and processing guidelines. This document follows guidelines authorized by the Department of Health and Human Services on September 17, 2001. The clarifications described herein include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options

Encounter data submitted to the Michigan Department of Community Health (MDCH) will be handled using the 837 transaction Provider-to-Payer-to-Payer Coordination of Benefits (COB) data model. Follow the Implementation Guide instructions for COB reporting guidelines.

(The Addenda implementation guide can be found at http://www.wpc-edi.com/hipaa/hipaa_40.asp. HHS guidance on data clarifications can be found at http://aspe.os.dhhs.gov/admnsimp/q0321.htm.)

NOTE: ***Page references*** from the Implementation Guides refer to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim, ASC X12N 837 (004010X098)** ("Version 4010"), unless otherwise noted (with an asterisk (*)) as referring to the Addenda Implementation Guides ("Version 4010A1"), **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim Addenda, ASC X12N 837 (004010X098A1).**

Page	Loop	Segment	Data Element	Comments
62		ST – Transaction Set Header		MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA-mandated implementation guide. Submissions with greater than 5,000 CLM segments in a single transaction (ST-SE) will be rejected.
65		BHT – (Header) Beginning of Hierarchical Transaction	BHT06 – Transaction Type Code	Use "RP" – Reporting.
11*		REF – (Header) Transmission Type Identification	REF02 – Transmission Type Code	Use "004010X098A1" if using the October 2002 Addenda Implementation Guide.
69	1000A – Submitter Name	NM1 – Submitter Name	NM109 – Submitter Identifier	Use the 4-character billing agent ID assigned by MDCH. This value should match GS02 (Application Sender's Code).
75	1000B – Receiver Name	NM1 – Receiver Name	NM109 – Receiver Primary Identifier	Use "D00111" for MDCH.
78	2000A – Billing/Pay-to Provider Hierarchical Level	HL – Hierarchical Level	HL01 – Hierarchical ID Number	HL01 must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.
86	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM108 – Identification Code Qualifier	Use "24" (EIN) or "34" (SSN).
86	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM109 – Billing Provider Identifier	Use the EIN or SSN value assigned to the provider ID identified in Loop 2010AA REF02 (Billing Provider Additional Identifier).
92	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use "1D" (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use "0B" (State License Number).
92	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF02 – Billing Provider Additional Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider use their state license number.
110	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	To identify MDCH's level of responsibility use "S" if the capitated plan is the only payer (that is, patient has no other insurance), "T" if there are any other payers.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide.

Page	Loop	Segment	Data Element	Comments
111	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR04 – Insured Group Name	Use “MICHILD” for children enrolled in the MIChild Program. Use “ABWI” for those enrolled in the Adult Benefit Waiver I Program.
112	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Use “MC” (Medicaid) for Michigan Medicaid, “TV” (Title V) for CSHCS, “OF” (Other Federal) for MIChild and ABWI, or “11” (Other Non-Federal) for State Medical Plan or for persons who are not enrolled in Medicaid. If recipient qualifies for more than one program, or other MDCH program not listed, use “MC” (Medicaid).
119	2010BA – Subscriber Name	NM1 – Subscriber Name	NM108 – Identification Code Qualifier	Use “MI” (Member Identification Number).
119	2010BA – Subscriber Name	NM1 – Subscriber Name	NM109 – Subscriber Primary Identifier	Use the patient’s 8-digit beneficiary ID number assigned by MDCH. For MIChild enrollees use the 8-digit Client Identification Number (CIN) assigned by the enrollment broker. For other persons not enrolled in Medicaid or MIChild, use the patient’s Social Security Number. Use the capitated plan’s unique identifier assigned to the patient **only** when the person is not enrolled in Medicaid or MIChild and the Social Security Number is unknown.
126	2010BA – Subscriber Name	REF – Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Use “SY” (Social Security Number).
127	2010BA – Subscriber Name	REF – Subscriber Secondary Identification	REF02 – Subscriber Supplemental Identifier	Use the patient’s Social Security Number. Report this value even when used in 2010BA NM109 – Subscriber Primary Identifier.
131	2010BB – Payer Name	NM1 – Payer Name	NM108 – Identification Code Qualifier	Use “PI” (Payor Identification).
131	2010BB – Payer Name	NM1 – Payer Name	NM109 – Payer Identifier	Use “D00111” for MDCH.
152	2000C – Patient Hierarchical Level			MDCH business rules require that the patient is always the subscriber. Therefore, MDCH does not expect health plans to submit any Loop 2000C (Patient Hierarchical Levels) in a transaction set. Transaction sets that contain Loop 2000C (Patient Hierarchical Level) information will be rejected.

Page	Loop	Segment	Data Element	Comments
170	2300 – Claim Information			Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 Claim Information within each Loop 2000B (Subscriber Hierarchical Level). Transaction sets that do not associate Loop 2300 Claim Information with Loop 2000B (Subscriber Hierarchical Level) will be rejected.
172	2300 – Claim Information	CLM – Claim Information	CLM02 – Total Claim Charge Amount	Report the total of the line item charges reported in 2400 SV102. A value of zero "0" may be reported.
173	2300 – Claim Information	CLM – Claim Information	CLM05-1 – Facility Code Value	Place of service codes are defined by the Center for Medicare and Medicaid Services (formerly HCFA). These codes can be obtained at cms.hhs.gov/state/poshome.asp
173	2300 – Claim Information	CLM – Claim Information	CLM05-3 – Claim Frequency Type Code	Use "1" on original encounter submissions; use "7" for encounter replacement, and use "8" for encounter void/cancel. For both "7" and "8", include the original Encounter Reference Number (ERN), as indicated in Loop 2330B REF02 (Original Reference Number).
217	2300 – Claim Information	CN1 – Contract Information	CN101 – Contract Type Code	Report this data element on encounters where the health plan contract arrangement with the provider is other than fee-for-service.
247	2300 – Claim Information	NTE – Claim Note	NTE01 – Note Reference Code	Use "ADD" (Additional Information).
247	2300 – Claim Information	NTE – Claim Note	NTE02 – Claim Note Text	Provide free-text remarks, if needed.
265	2300 – Claim Information	HI – Health Care Diagnosis Code	HI01 – Principal Diagnosis	MDCH requires this element on every encounter. Do not use a decimal point.
40*	2310A – Referring Provider Name	PRV – Referring Provider Specialty Information	PRV03 – Provider Taxonomy Code.	Use taxonomy codes from the Health Care Provider Taxonomy Code List (provider specialty code), which is available at www.wpc-edi.com.
288	2310A – Referring Provider Name	REF – Referring Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use "1D" (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use "0B" (State License Number).
289	2310A – Referring Provider Name	REF – Referring Provider Secondary Identification	REF02 – Referring Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
292	2310B – Rendering Provider Name	NM1 – Rendering Provider Name	NM108 – Identification Code Qualifier	Use "24" (EIN) or "34" (SSN).

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Page	Loop	Segment	Data Element	Comments
292	2310B – Rendering Provider Name	NM1 – Rendering Provider Name	NM109 – Rendering Provider Identifier	Use the EIN or SSN value assigned to the provider identified in Loop 2310B REF02 (Rendering Provider Secondary Identifier).
41*	2310B – Rendering Provider Name	PRV – Rendering Provider Specialty Information	PRV03 – Provider Taxonomy Code	Use taxonomy codes from the Health Care Provider Taxonomy Code List (provider specialty code), which is available at www.wpc-edi.com.
296	2310B – Rendering Provider Name	REF – Rendering Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number).
297	2310B – Rendering Provider Name	REF – Rendering Provider Secondary Identification	REF02 – Rendering Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
319	2320 – Other Subscriber Information	SBR – Subscriber Information		Community Mental Health encounters requires this loop once for the Prepaid Inpatient Health Plan (PIHP) and once for the Community Mental Health Service Program (CMHSP) Affiliate, where applicable. Other payers such as Medicare or other commercial carriers are reported in additional iterations of this loop.
319	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	If the patient has Medicare or other insurance, report that coverage with code “P” or “S”, as appropriate, and the capitated plan coverage with “S” or “T”, as appropriate. If the patient has no other insurance, report the capitated plan coverage with “P”.
319	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR02 – Individual Relationship Code	The code carried in this element is the patient’s relationship to the person who is insured. For example, if a child with Medicaid also has coverage under the father’s insurance, use code “19” (Child).
320	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR03 – Insured Group or Policy Number	Use the subscriber’s group number (assigned by the capitated plan or other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits.
321	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR05 – Insurance Type Code	Community Mental Health encounters should report “MC” for Medicaid Fund and “OT” (Other) for General Fund.
321	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Community Mental Health encounters should report “MC” for Medicaid Fund and “11” (Other Non-Federal) for General Fund.

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Page	Loop	Segment	Data Element	Comments
332	2320 – Other Subscriber Information	AMT – Monetary Amount	AMT01 – Amount Qualifier Code	Use “D” Payor Amount Paid.
332	2320 – Other Subscriber Information	AMT – Monetary Amount	AMT02 – Payor Paid Amount	Report the total of the service level paid amounts reported in 2430 SVD02. A value of zero “0” may be reported.
351	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM103, NM104, NM105, NM107 – Other Insured Last Name, First Name, Middle Name, Suffix	Use the name of the subscriber as it appears on the files of the capitated plan or other payer.
352	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM108 – Identification Code Qualifier	Use “MI” (Member Identification Number).
352	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM109 – Other Insured Identifier	Use the unique member number assigned to the subscriber by the PIHP, CMHSP or other payer indicated in Loop 2330B. For PIHPs and CMHSPs this is an 11-character “CON” ID. For BCBSM members, the numbers assigned are usually 3 letters followed by 9 digits.
357	2330A – Other Subscriber Name	REF – Other Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Do not use “1W” (Member Identification Number).
360	2330B – Other Payer Name	NM1 – Other Payer Name	NM108 – Identification Code Qualifier	Use “PI” (Payor Identification).
361	2330B – Other Payer Name	NM1 – Other Payer Name	NM109 – Other Payer Primary Identifier	For the PIHP/CMHSP, use the 9-digit Payer ID assigned by MDCH. For example “171234567”. For other payers, use the carrier code assigned by MDCH (see MDCH website for listing of carrier codes). For example, if BCBSM Traditional were the Other Payer, the value (carrier code) carried in this element would be “00029005”. For Medicare Part A (United Government Services) use “00452”. For Medicare Part B (Wisconsin Physician Services) use “00953”.
368	2330B – Other Payer Name	REF – Other Payer Secondary Identification	REF01 – Reference Identification Qualifier	For the capitated plan, use “F8” (Original Reference Number).
369	2330B – Other Payer Name	REF – Other Payer Secondary Identification	REF02 – Other Payer Secondary Identifier	For the capitated plan, enter the plan-assigned unique identifier (encounter reference number) for the encounter.

Page	Loop	Segment	Data Element	Comments
370	2330B – Other Payer Name	REF – Other Payer Prior Authorization or Referral Number	REF01 – Reference Identification Qualifier	Use “9F” (Referral Number) or “G1” (Prior Authorization Number).
371	2330B – Other Payer Name	REF – Other Payer Prior Authorization or Referral Number	REF02 – Other Payer Prior Authorization or Referral Number	If the capitated plan or other payer pre-authorized services or a referral, enter the authorization number or referral number here. Do not use the Prior Authorization or Referral Number (Loop 2300 REF02 - Prior Authorization or Referral Number), which is specific to the destination payer.
380	2330D – Other Payer Referring Provider	REF – Other Payer Referring Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
384	2330E – Other Payer Rendering Provider	REF – Other Payer Rendering Provider Secondary Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
388	2330F – Other Payer Purchased Service Provider	REF – Other Payer Purchased Service Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
392	2330G – Other Payer Service Facility Location	REF – Other Payer Service Facility Location Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
396	2330H – Other Payer Supervising Provider	REF – Other Payer Supervising Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
398	2400 – Service Line			The HIPAA Implementation Guide allows up to 50 repetitions of the 2400 Service Line Loop for each 2300 loop.
56*	2400 – Service Line	SV1 – Professional Service	SV101-2 – Procedure Code	Use the PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes list posted on the MDCH website.
402	2400 – Service Line	SV1 – Professional Service	SV102 – Line Item Charge Amount	Use the provider’s usual and customary charge or billed amount. A value of zero (0) may be reported.

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Page	Loop	Segment	Data Element	Comments
466	2400 – Service Line	CN1 – Contract Information	CN101 – Contract Type Code	Report this data element on encounters where the health plan contract arrangement with the provider is other than fee-for-service.
485	2400 – Service Line	AMT – Monetary Amount	AMT01 – Amount Qualifier Code	Use “AAE” Approved Amount.
485	2400 – Service Line	AMT – Monetary Amount	AMT02 – Approved Amount	MDCH requires the PIHP calculated approved (allowed) amount for all services reported. A value of zero “0” should not be reported.
73*	2410 – Drug Identification	LIN – Drug Identification	LIN03 – National Drug Code	This element may be used to report prescribed drugs that may be part of the service(s) described in Loop 2400 SV1 (Professional Service). MDCH will only process the first iteration of Loop 2410 LIN (Drug Identification). Any additional repeats may be ignored.
79*	2420A – Rendering Provider Name	PRV – Rendering Provider Specialty Information	PRV03 – Rendering Provider Taxonomy Code	Use taxonomy codes from the Health Care Provider Taxonomy Code List (provider specialty code), which is available at www.wpc-edi.com.
554	2430 – Line Adjudication Information			MDCH expects this loop to be populated for each payer identified in Loop 2320 (Other Subscriber Information).
555	2430 – Line Adjudication Information	SVD – Service Line Adjudication	SVD02 – Service Line Paid Amount	Report the amount paid to the provider. A value of zero “0” may be reported.
560	2430 – Line Adjudication Information	CAS – Claims Adjustment		MDCH expects claim adjustment information when the value reported in Loop 2400 SVD02 (Service Line Paid Amount) is not equal to the value reported in Loop 2400 SV102 (Service Line Item Charge Amount). MDCH expects health plans to use the HIPAA-mandated Claim Adjustment Reason Codes to report the reason for the difference.